Commissioner's Task Force on Safety and Risk Management Report

Department of Mental Health

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Purpose

The Task Force was appointed by the Commissioner with the broad mandate to identify current safety and risk management practices implemented by the Department of Mental Health within DMH Areas and in concert with community-based providers; consider the current capacity of the Department to support safety and risk management practices for persons who can pose significant safety and risk management challenges. The Task Force considered persons: (a) with histories of physical and/or sexual violence towards others; (b) histories of self-harming conduct that could result in significant injury or death; and/or, (c) medical compromise that complicates community-based provision of necessary medical and mental health services.

Process

Monthly Task Force meetings of two hours duration each were held beginning in June 2005 and concluding in March 2006. Additionally, subgroups were formed to consider legal and privacy issues, challenges arising along the continuum of care from inpatient units through independent community living, training needs, and specific protocols for assessing risk.

A subcommittee chaired by Debra Pinals, M.D. was established to review tools used in violence risk assessment and to make recommendations about a universal protocol for identifying and assessing risk domains. The final report of that subcommittee and a proposed risk identification tool subcommittee are included as attachments to this report.

It became clear early on that it would not be possible to comprehensively address all potential risk domains due to the impossibly broad scope of attempting to address all safety and risk management issues for all kinds of risk domains. Therefore, the Task Force focused upon risk of violence to others to: (1) identify issues common across clinical and risk management of different risk domains, and (2) craft a model protocol that could also be adapted readily to identify, assess, and manage other risk domains.

The risk of violence to others was selected because there was sufficient expertise in this area among Task Force members, and because it is currently so topical an area for DMH policy and practice. The model for identification, screening, assessment and risk management that emerged is recommended as the basic protocol for other risk domains as well.

While utilizing risk of violence posed to others as a model for devising a template for risk identification and management practices, the Task Force identified the following risk domains as critical to incorporate in DMH planning and implementation of risk management strategies across all Areas and levels of care:

1 Physical violence to others
2 Sexually aggressive and other sexually problematic behavior
3 Chronic self-harming or potentially suicidal behavior
4 Significant medical compromise, including neurological compromise
5 Risk of victimization by others

Because of the expertise of Task Force members, the recommendations in this Task Force report are weighted towards management of safety and rise management of violence risk towards others. However, the overall intent of the Task Force report is to use risk of aggression towards others as an example of how DMH might best manage safety and risk management across the five domains of risk management that are identified above. The use of risk management of physical violence towards others as a template for more general risk management strategies should in no way be understood as an endorsement of the notion that DMH consumers are as a group more likely than other members of a community to be violent towards others.

Substance abuse was not specifically identified as a separate risk domain. The Task Force felt that it was a pervasive and exacerbating problem across all of the risk domains. Effective assessment of substance abuse and its impact upon psychiatric care and recovery is a standard element of quality clinical care. Task Force members also felt that isolating it as a separate issue perpetuated an existing tendency to distinguish between psychiatric illness and addiction in a way that diminishes effective attention to dual diagnosis issues among DMH clients represented in one or more of the risk domains.

Task Force members had the opportunity to comment upon drafts of this Report. It was not possible to achieve full consensus on all recommendations and this Report includes summaries of differing perspectives on recommendations where consensus was not achieved. Task Force members were also offered the opportunity to indicate for the record their individual concerns or objections to the Report in the form of statements in the body of the Report.

Background for the Task Force

DMH policy and practice is dedicated to the support and treatment of its clients in the least restrictive and most clinically appropriate setting. Over the past 20 years, DMH has focused upon maximizing the number of clients who can be effectively served and integrated into the community. These efforts are reflected in the diminishing number of institutional beds, particularly inpatient unit beds, and increasing supports to clients and community-based providers. This has included the movement away from long-term inpatient care and congregate housing towards creation of a continuum of options for clinical care, housing, supported employment, and other dimensions of community-based supports. DMH has embraced a philosophy of engagement, individualized service planning, and active case and utilization management. For many clients, some of whom had previously spent years to decades on state hospital inpatient units, this has provided new opportunities for recovery and fulfillment in the community.

Not all clients are able to make the transition from hospital to community without significant behavioral challenges, nor can all clients function consistently in the community without periodic difficulties. Barriers to state hospital discharge often include some combination of medical compromise, unresolved psychosis, and/or history of physical or sexual aggression or misconduct. Recent DMH data analysis reflects that approximately one-third of continuing care beds are utilized by persons who, on average, have two or more of these barriers to discharge; over half of these persons have been hospitalized for more than three years.

Even once discharged, these same barriers to discharge may become barriers to successful community integration or become the basis for return to state hospital inpatient care. When the behavioral challenges involve physical or sexual assaults or other criminal activity, clients may not only inflict harm upon others but become involved in the criminal justice system, potentially incarcerated or with psychiatric care often imposed as a condition of probation or parole.

A cohort of 13,876 DMH clients followed from 1991 – 2000 reflects the elevated exposure to criminal justice involvement of persons receiving DMH services (Fisher, et al, 2006). In the ten year study period, 27.9% (3856) were arrested at least once, with 13.6% (1847) arrested for a serious violent crime, 9.5% (1306) arrested for a serious property crime, and 15.7% (2166) arrested for “subsistence” crimes. Unfortunately, 19.9% of the total cohort was charged with at least one felony during the study period. Data from the DMH Internal Affairs database also demonstrates alarmingly elevated

mortality and morbidity rates among DMH clients, and potentially lethal self-harming conduct is a frequent precipitant of acute and continuing care hospital admissions.

For some persons, difficulty arises largely because of the expression of psychiatric illness alone. For others, it arises because of the interplay of substance use, poverty, clinical care factors, or other factors with severe and persistent psychiatric illness. For still others, behavioral health issues contribute to earlier onset of chronic medical compromise. And because mental illness has no demographic boundaries, for some persons their difficulties arise because of criminal activity that is independent of their mental illness but which can be complicated by psychiatric symptoms.

There are many and often complex reasons why individual clients cannot or do not engage effectively in their own recovery, at least at times. However, when difficulties include serious or potential lethal physical aggression towards others, sexual misconduct, serious or potentially lethal self-harm, significant deterioration of medical status, fire setting or other conduct with potentially significant or even irreversible consequences, the stakes for the client, others interacting with the client, the communities in which most clients live, and the Department are very high.

One challenge posed by these circumstances, particularly if there is physical or sexual aggression against others, is that they reinforce the deeply stigmatizing stereotype of a strong association between major mental illness and violence towards others. The research is clear that, as a group, persons with major mental illness are less likely to be perpetrators of serious crimes against others than are community cohorts, and more likely to be the victims of crime. If there is a relationship between mental illness and violence against others, it is not as robust as stereotypes would suggest. Moreover, any association between violence and mental illness is a complex one mediated by other critical factors such as substance abuse, active psychosis, poverty, the adequacy of social supports and clinical care, and social and community context.

The Department's client population has always included persons whose mental illness is accompanied by risk behaviors. The Department has evolved a variety of strategies for identifying and responding to the intervention and risk management needs of clients, ranging from the MI/PSB initiative to Area and Site based protocols and procedures.

Overview of the Commissioner's Task Force on Safety and Risk Management

This Task Force was formed in recognition of the need to identify and implement best-practices to support safety and sophisticated risk assessment and management across the continuum of care. There are several reasons for the appointment of the Task Force on Safety and Risk Management:

(1) The Department is strongly committed to the highest quality of clinical care. Adequate support for safety and implementation of risk assessment and management practices are an essential component of quality clinical care. Therefore, solutions for the challenges posed in risk management are not solely a matter of developing expertise and practices that seem as an enterprise apart from the provision of clinical care and services in support of recovery. Rather, quality clinical care includes sophisticated risk management practices and the Department recognizes that it must be deeply committed to effective processes of continuous quality assurance and improvement, creation of a sustained culture of care and safety, and support of ongoing efforts to identify areas for improvement in professional practice. Specific adverse incidents are rarely inevitable. They are often the culmination of a series of practices, decisions or events that must be subject to scrutiny as an opportunity for learning and improved practice.

(2) The Department recognizes the high prevalence of traumatic experiences among its clients and has launched initiatives to support the safety of clients and staff, including the recent Restraint and Seclusion Reduction Initiative. Minimizing violence of all kinds on inpatient units is an essential strategy for establishing the basic safety required for a therapeutic environment. Similarly, clients served in the community require provision of basic safety in housing, clubhouses or other settings to optimally establish and maintain effective recovery. Therefore, safety and risk management initiatives span the range of services offered across the DMH continuum of care. These initiatives attend to the vulnerabilities of many DMH consumers and reflect attention to both their potential for victimization by others and risks that some may at times pose to themselves or others.

This Task Force is a complement to the other recovery-oriented activities supported by the Department, including the Restraint and Seclusion Reduction Initiative ("the Initiative"). The Initiative holds that physical management and isolation of inpatient clients is a traumatic experience occurring among persons where lifetime incidence of exposure to traumatic experiences is already disproportionately high. The Initiative requires that clinical care providers intensively involve the person in identifying and managing those situations most likely to otherwise result in physical management; alternatives to physical management, restraint or seclusion are individually identified with each inpatient client. This Task Force also acknowledges that situations that might provoke a restraint or seclusion are traumatic to the individual patient, other patients on the unit, and the staff. These situations often involve threatened or actual harm to self or others. The Task Force also endorses the view that individuals receiving clinical care must be actively engaged in efforts to minimize the frequency or the impact of situations in which they or others are victimized or traumatized. Many of the clinical steps

recommended by the Initiative to reduce restraints and seclusions (e.g., identifying triggers, management of stressors, alternatives to confrontation) are very similar to steps that can be taken to manage risk domains.

(3) The Department recognizes the unique treatment, rehabilitation and support needs of persons with mental illness, including persons who at times behave in ways that pose risks to themselves and/or others. Massachusetts and other states have, through experience and expertise, demonstrated the commitment and ability to support in the community many individuals who would have had prolonged and/or repeated inpatient admissions. However, community-based providers reported to the Commissioner that their staff and programs were challenged and sometimes overwhelmed by the behavioral and risk management issues posed by some individuals, and asked the Department to consider how to best support their efforts to serve these individuals in the community. Additionally, adverse outcomes in the community can substantially compromise the ability of providers to site housing, clinical care or other critical support services, particularly if the adverse outcomes attract media attention.

(4) Helping persons with mental illness to live successfully in community settings requires effective clinical and rehabilitative interventions, including ongoing risk assessment and management. Just as with persons without mental illness, it is both impossible and undesirable to eliminate all risk. Acceptance of risk is part of adult functioning and is as basic as deciding in what activities we will engage, with whom, and where. Therefore, it is undesirable to have total elimination of risk as a goal.

One critical issue in planning for consumer services is the prudence of the risk assumed and the integrity of the process by which risk is assessed, understood and incorporated in decision-making. This is always a highly individualized process some clients are more capable than others of effective participation in mental illness self-management and recovery, including recognizing and managing their own risk. The Department recognized that adopting and implementing risk assessment and management strategies along the entire continuum of care from inpatient units to independent living in the community is an essential component to the initiative to serve the most persons possible in the least restrictive, most clinically appropriate setting possible.

A second critical issue is that there are different approaches to risk management and risk tolerance. In some cases, there is essentially a “zero tolerance” for risk and an adverse outcome is intolerable; in these cases the degree of risk to be allowed is minimal.

For example, a person with ongoing depression and a history of impulsive and potential lethal suicide attempts without clear precipitants is likely to require greater monitoring than a person who may engage in self-harm unlikely to result in death or serious injury in response to well-identified and observable triggers. A person with significant cognitive deficits with a history of repeated serious physical or sexual victimization by third parties when unsupervised in the community will require greater supervision than persons with a history of victimization but who are less vulnerable and more capable of protecting their own safety. In these situations, the combination of the severity of potential adverse

outcome to the person and a relative incapacity on the part of a person to contribute to managing their own risk warrants establishing a "zero tolerance" for risk and greater external supports and supervision.

In other cases, more risk might be tolerated because the goal is "harm reduction" over time (such as diminishing illegal drug use that does not pose an immediate serious risk to health) and because the person appears to be capable of productive engagement in illness self-management (such as a person with a history of suicide attempts who is now capable of communicating distress and participating in supports).

What is critical is that there be *clear and consistent* communication about how much risk tolerance is permissible in individual cases or for programs serving persons at higher risk in one or more risk domains. It is impossible to consistently share risk until there is clarity about what risk is being shared, with what tolerance for adverse incidents, and with what consequences to whom in the event of an adverse incident. Furthermore, when working with persons at risk it is critical to clarify lines of communication, accountability and responsibility.

Summary of Core Principles

The Task Force evolved over time a set of core principles that shaped its discussions and recommendations. These core principles were:

1. **The majority of persons with severe and persistent mental illness are best supported in their recovery and in the management of risks arising from mental illness through provision of appropriate and high quality clinical, rehabilitation and support services; respect for privacy and autonomy; and, assistance in overcoming stigma and other barriers to full participation in communities.** Persons with severe and persistent mental illness ordinarily can succeed in achieving their individual level of optimal recovery through provision of appropriate clinical care, rehabilitation services and supports. This includes attention to stigma and deference to protections of privacy and autonomy in law and effective clinical practice, and provision of advocacy and support to overcome barriers that may undermine integration into communities.

2. **All persons are entitled to basic safety**. Consumers, family members, peers, clinical care and other service providers in all roles and at all levels of care, and community members are all entitled to basic safety. Recovery cannot advance in the absence of a basic sense of safety or sense of genuine participation in managing one's life, including any risks posed to the safety and well-being of self and others. However, persons in recovery must often take risks in furtherance of their own recovery. Therefore, the core issues are the prudence with which decisions regarding safety and risk management are made, who makes those decisions and who bears the risks of an adverse outcome, and how consumers and those who support their recovery also effectively support basic safety for self and others.

3. **Safety and risk management practices are at the core of the provision of adequate clinical care in hospital and community settings**. Safety and risk management strategies are integral to adequate clinical care and not a separate enterprise, although sometimes specialized consultation and planning may be required to meet the needs of persons receiving services or clinical care. Consumers, family members, the Department of Mental Health, and clinical care and other services providers are all responsible for contributing to the basic safety of the consumer and others, and for engagement in adequate identification and management of risks.

4. **Safety and risk management practices must rely fundamentally upon positive engagement with each consumer**. The consumer's voice must be genuinely incorporated into safety and risk management planning and implementation. Where appropriate, the engagement of family members, peers, and other interpersonal supports must be engaged to create collaborative efforts that optimize safety for the consumer and for others.

5. **Clinical care and other service providers have an obligation to engage and educate consumers regarding their mental illness symptoms, and to help consumers understand and manage the conduct or circumstances that pose risks to themselves or to others**. Engagement, education and risk management planning and implementation must be highly individualized, ongoing and embedded in the provision of clinical care and other services. Peer supports and family supports are often important components for effective engagement with the consumer and for effective advocacy for the needs and interests of the consumer. It is incumbent upon DMH to educate consumers about their specific conduct that poses risks to successful community living and to effectively advocate on behalf of consumers regarding other potential barriers to this success (e.g., housing restrictions, SORB notifications). Ultimately, the goal of clinical care and the provision of other services at all levels of the continuum of care is to support recovery and successful community living (or the least restrictive alternative) and the achievement of optimal potential by each individual served by the Department.

6. **There may be tensions between personal autonomy and intrusions upon personal autonomy intended to prevent or mitigate harm to self or to others**. Always to the greatest extent possible, consumers must direct their own care and be responsible for their own safety and the management of any risks that are posed by them to themselves or others. Appropriate engagement by DMH and the service provider on these issues is also essential.

Persons vary in their willingness or ability to support their own recovery and manage their own safety needs. This is one of the implications of a "stages of change" approach that recognizes that persons may be at different levels of engagement in their recovery. Strategies that may be effective in support of recovery for one person at a particular point in their recovery process may not be equally appropriate or effective for other persons at different points of engagement in recovery. A highly individualized approach to supporting recovery that is sensitive to issues of autonomy, dignity and personal

aspiration is required to address the variability of engagement in recovery.

Persons eligible for DMH services typically have severe and persistent mental illness that has significantly impacted their functioning. At least at times during the course of the illness, capacities for self-care, self-protection, judgment, or management of stressful social interactions have been compromised. Nevertheless, every effort should be made to support and safeguard the autonomy and dignity of persons with mental illness. This requires a highly individualized approach to supporting recovery that is sensitive to autonomy, dignity and personal aspiration and obligates DMH to embrace practices that do so. It also requires that DMH work collaboratively and proactively with individuals and families. When the impact of mental illness sufficiently erodes the ability of an individual to make choices in their own interests—whether or not we agree or disagree with the choices made—then DMH has a duty to do what it can legitimately to minimize the risks posed to self or others that arise from impairment.

When the risks involve harm to third parties, DMH must respect the individual rights of consumers and yet balance this with its responsibility to take reasonable steps to protect other consumers and public safety. **To this end, the Task Force broadly recommends that DMH develop a clear set of standards, policies and procedures that fully comply with all privacy laws and which clearly defines when, where and how information will be shared to ensure consumer or public safety**.

This recommendation raised a variety of concerns from some Task Force members. These included the following concerns: (a) the effort to manage the risks posed by a minority of DMH consumers might erode the rights and interests of the majority of DMH consumers, including persons on DMH inpatient units; (b) a focus upon the balancing of rights and interests of those served by DMH could shift focus away from the responsibility of DMH and service providers to appropriately and consistently engage, inform and serve eligible persons; and, (c) as written, the recommendation did not capture the complexity of making decisions that might involve issues of privacy and autonomy.

Other Task Force members commented that: (a) DMH already grapples with these issues but lacks a clear and transparent discussion of what guides decisions and how they are made; and, (b) failure to effectively attend to individuals who pose elevated risks, particularly when the risk involves potentially significant harm to other DMH consumers or third parties, may compromise the ability of DMH and service providers to serve or house the majority of DMH clients in community settings.

7. **There may be tensions between the confidentiality that protects the privacy of an individual and the clinical care received by that individual, and the need at times to share within a framework of law and best practices the information required to identify, communicate about, or manage risk**.

Effective risk assessment relies on a thorough and complete knowledge of a consumer's history and current factors related to their risk potential. This requires access to information about a consumer in compiling a detailed history for risk management planning purposes. It also requires appropriate communication before, during and after potential crisis incidents. One key implication of the importance of detailed relevant information is that staff along the entire continuum of care –especially clinically trained and supervisory staff--must embrace a clinical care model that includes gathering a detailed history, completing a comprehensive assessment, and integrating that assessment into planning and clinical care of each individual. It is essential that staff must be afforded the time to do so, and they must be provided the support and training to make sophisticated use of the information they obtain.

However, information can be misused or used in a way that profoundly and sometimes maliciously stigmatizes an individual. This is what gives rise to the need for privacy protections such as confidentiality in the first instance. While information may be necessary for identification and management of a variety of potential risks, the person about whom the information still has a legitimate interest in privacy. The person about whom information is being gathered or shared should be involved from the outset and to the greatest extent possible in determining how this information gathering and sharing process will be initiated and implemented. In some cases, a balance will have to be carefully struck among individual interests in privacy or safety, interests of consumers and other third parties in safety, and the obligation of DMH and service providers to both protect privacy and support safety for those they serve.

Information may need to be shared to: (a) preserve the transparency of safety and risk management practices; (b) adequately inform other clinical care and service providers of the ongoing or urgent safety and risk management needs of the individual; (c) allow for the protection of third parties from risks posed by an individual; (d) protect the individuals from the adverse consequences of judgments made when unduly impaired by their mental illness; or (e) for other reasons. Information shared for these purposes must be shared within the evolving framework of law and "best practices" that exist to guide the release of otherwise protected information. Disclosure of information that occurs without the authorization of the consumer or the consumer's legal guardian or representative must be strictly limited to that information required to achieve a clearly articulated safety goal.

Some Task Force members noted that there is already a legal duty to warn or protect third parties that should be sufficient offer protection from risk of violence. They were reluctant to take steps that might both establish a separate legal duty and effectively lower the threshold for communication of otherwise protected information. Additionally, they held that current procedures for case-by-case determinations regarding releasing

information without authorization were sufficient to address individual situations.

Other Task Force members agreed that there is a legal duty to warn but held that the threshold is a high one and a mechanism should be in place to communicate about persons to prevent situations from escalating to the point where that legal duty is triggered. Still other members distinguished the controversy about the legal duty to warn from a more general clinical duty to gather and integrate sufficient information about a person to yield both appropriate clinical care and adequate risk management.

8. **Legal and regulatory frameworks must also reflect the challenges posed by clients who present significant risk to their own safety or the safety of others.** A framework of law, regulation and practice that has evolved to serve the legitimate interests of most persons for their autonomy and privacy is, in some cases, a poorer fit when accessing and exchanging information critical to the safety and risk management of persons who pose significant risks to themselves and/or others and who are unable or unwilling to effectively participate in managing the risks they pose. Need to take effective risk management steps in some cases may arise before a legal "duty to warn" threshold is reached. Indeed, effective proactive steps may preclude the need to make mandated "duty to warn" disclosures**.**

DMH needs a clear and transparent framework of law, regulation and professional practice to carefully balance the rights and interests of those involved in situations where decisions must be made that implicate interests in privacy, autonomy and the safety of self and others.

This recommendation generated comments very similar to those prompted by Recommendation Seven. As with Recommendation Seven, some Task Force members expressed serious concerns about the potential impact of Recommendation Eight upon the legitimate protection of the privacy, autonomy and other civil rights of DMH consumers. They held that current procedures are adequate to address risk situations.

Other Task Force members felt that current protections of privacy and autonomy that legitimately serve most DMH consumers may not be sufficiently flexible to meet challenges posed by persons who are high risk to themselves or others but unwilling or unable to participate in their own risk management. The differing perspectives on both Recommendations Seven and Eight were strongly held by their adherents.

9. **Management of risk must be shared at all service levels**. Consumers must be engaged to share and actively participate in the management of risks that they may pose towards self or others. Similarly, risk management for particularly vulnerable consumers or those who are not currently willing or able to consistently participate in their own risk management must be shared among clinical care and other service providers, families and others. For example, for persons who pose ongoing risks to themselves or others there must a shared sense of responsibility among DMH and other providers that is reflected in sophisticated and prudent continuity of care across all levels of hospital and community-based care.

Such a continuity of risk management and clinical care provision will require the ability to identify and collaboratively manage different kinds and intensities of risk to self or others. It will require a flexibility of policies, resource allocations, and practices that are often currently quite challenging. Ultimately, the consumer bears responsibility for, becoming knowledgeable about, and actively participating in managing their own mental illness. Where consumers have been legally deemed incompetent and/or where they are otherwise unwilling or unable to manage their own risks, DMH and service providers have a shared responsibility to manage risk together as effectively as possible within relevant law, DMH regulation and practice, and appropriate clinical care.

While identification and management of risk must be a responsibility shared by all who have a stake in the provision of effective clinical care, services and supports, this does not mean that that the responsibility is diffuse. Rather, there must be a clearly designated point of clinical accountability in a system in which information, operational responsibility and decision-making authority reliably flows to the point of clinical accountability from all who play a role in risk management.

10. **Consistent risk management practices should be developed for the DMH continuum of services and care.** The Department has evolved elements of safety and risk management practices in all Areas and across all levels of care. Many of these practices are very effective. However, these practices have evolved largely subject to local histories, events, capacities and leadership. Effective practices in some Areas are not replicated in other Areas. Similar practices are referred to by different terms and vocabularies. Some seek to proactively bridge from DMH hospital care to community providers, others focus more internally upon managing safety and risk while in the hospital with less attention to a bridging function with community providers. The attention and sophistication brought to bear on integrating clinical care and risk management varies widely in individual cases and across all levels of care.

DMH would be wise to identify and implement across Areas and all levels of care a basic and consistent structure of risk identification and management. This basic structure should include standard protocols for identifying and assessing risk domains, accessing specialized assessments and consultations, communicating about risks within DMH and outside of DMH, and planning and implementing risk management strategies for individuals served by the Department. Additionally, DMH must systematically incorporate administrative and service provision systems that provide visible, accessible and effective “bridging” across and between levels of care.

The Department has pockets of expertise in safety and risk management practices that inform its best practices, but no clear manner to identify and make the most of this expertise. DMH at all organizational levels should look for opportunities to coordinate initiatives with significant safety and risk management implications.

11. **Children, adolescents and those now identified as "transition-aged youth" must be given special consideration as safety and risk management initiatives are planned and implemented within the Department**. Recent Department initiatives for "transition-aged youth" in particular arose from the recognition that youth and young adults with psychiatric illness are at elevated risk for arrest, development of substance abuse, inpatient hospitalization due to risks posed to themselves, homelessness, unemployment and economic dislocation, and failure to receive developmentally appropriate clinical care and other services. While there will need to be some modifications of the Task Force recommendations for the continuum of care for children, adolescents and "transition aged youth," the substance of the Task Force Report and recommendations also apply to safety and risk management challenges for younger persons served by DMH.

12. **There is a "double stigma" that pervasively operates to disadvantage some persons served by the Department**. While many in the Department are comfortable working with persons with mental illness, many are less comfortable when there is also a history of incarceration or uncharged physical and/or sexual aggression towards persons. This can result in: (a) diminished efforts to engage these persons in their own recovery; (b) conflict within the Department about how to best understand or respond to individuals who pose behavioral challenges; (c) unnecessarily prolonged stays in hospital or other institutional care (including incarceration settings); (d) and increased likelihood of failure to engage with or respond to community-based services. Overcoming the impact of this "double stigma" is an important component to modifying current policies and practices to best support these individuals.

Strategic Challenges and Recommendations

Strategic Challenge One: A culture of shared risk and clinical care practices that support the safety and recovery of consumers needs to be more consistently developed. Participants in achieving goals of safety, shared risk and recovery include consumers, families, staff of the Department, providers of contracted inpatient and community-based clinical and other services, and other organizations that interact with DMH and consumers.

Recommendations in support of developing this culture and practices that consistently reflect it include:

a. **Privacy and Confidentiality.** DMH should review its current regulations regarding confidentiality and its current process by which "best interest" exceptions to confidentiality are made. Current practices governing confidentiality are subject to considerable variation of interpretation and implementation. Standard protections of confidential information that are necessary and appropriate for some persons may not be as good a fit for persons who pose significant risks to themselves or others and are either unwilling or unable to effectively participate in managing the risks they pose. Expectations should also be clear regarding the sharing of information at times where risk may be heightened but where a situation has not yet deteriorated to the point where an "emergency" exception to confidentiality may be cited. A process for timely determinations of a "best interest" exception needs to be created.

b. **Access to Criminal History Records.** Current initiatives should be completed to articulate and implement a DMH policy permitting access to CORI information on DMH consumers in the community under specific circumstances.

Relevant law, regulation and policy should be reviewed to see whether it is permissible and desirable to create a capacity for criminal history from CORI to be shared directly with inpatient treatment teams for purposes of clinical care and risk management planning.

c**.** **Consideration of Criminal Justice System Responses in Some Circumstances.** Commissioner's Directive 14 discourages filing of criminal charges by DMH facilities against DMH inpatients. This is entirely appropriate when problematic behavior arises from psychiatric illness since there is a considerable risk that mental illness can become criminalized. However, there are also persons with mental illness who to use threatened or actual misconduct and who harm others to achieve instrumental goals. These can include interpersonal control through intimidation, access to non-consenting sexual partners, access to resources or objects belonging to others, and so forth. Instrumental and even predatory use of threatened or actual violence can occur on inpatient units and in the community. Violence occurring on inpatient units can be profoundly traumatizing, destabilizing and counter-therapeutic for patients and staff on these units; violence occurring in the community can exacerbate the stigma associated with mental illness,

reinforce the stereotype that persons with mental illness are particularly violent, and compromise the siting of housing and services for DMH consumers. Admittedly, it can be difficult to differentiate in individual cases whether the violence arises from criminal orientation, responses to acute stressors, psychiatric vulnerability, or some combination of these.

Nonetheless, the Task Force recommends a review and refinement of Commissioner's Directive 14.

Additionally, providers have stated that they are unclear about DMH's position on use of the criminal justice system to respond to some incidents in the community. DMH should issue a position statement on this issue for internal use and for use by providers. This will ensure a consistent response by DMH to its providers and offer guidance and clearer expectations for providers. For example, Commissioner's Directive 14 should be reviewed to offer guidance about the use of criminal justice involvement for DMH consumers in community setting with the goal of minimizing criminalization of behavior related to mental illness while also acknowledging that DMH consumers are as accountable for their conduct as other citizens when their conduct is unrelated to their mental illness.

This recommendation prompted considerable controversy among Task Force members. Some members forcefully argued that criminal justice and mental health responses should be sharply distinguished and could not support a recommendation that would place DMH in the position of supporting the filing of criminal complaints. These members tended to agree that it is sufficient to maintain the current practice of allowing staff or other patients on inpatient units to decide whether or not to press criminal charges when they were victims. Some were very concerned about the difficulty of differentiating between situations calling for a criminal justice response and a mental health response and worried that a criminal justice response would be relied upon in a punitive manner for particularly challenging individuals. Some felt that if the core problem is difficulty managing violence on inpatient units, then attention to Directive 14 is misplaced. Members sharing these concerns ranged from a rejection of the recommendation entirely to supporting a general recommendation only that the Directive should be revisited.

Other members, while agreeing that determining whether a criminal justice and/or mental health response can be difficult in individual cases, forcefully held that Directive 14 in some cases has the effect of diminishing an effective response to dangerous behavior that is calculated, criminal and even predatory. As a result, violent conduct that warrants a criminal justice response is not effectively contained in some cases, resulting in significant compromise of the safety of staff and other patients and destabilization of the therapeutic environment of an inpatient unit. These members also supported the call for review of DMH's position on violence committed in community settings; these members were generally supportive of such a review as part of a broader strategy of trying to share responsibility with community providers and protect the interests of DMH consumers and others who may be the targets of violence.

d. **Consideration of Community Oversight Mechanisms for Specific Forensic Populations.** The Department may wish to revisit the issue of conditional release mechanisms for persons who have committed violent physical and/or sexual crimes against persons and who have then been found Incompetent to Stand Trial or Not Guilty by Reason of Insanity on those charges.

Task Force members commenting upon this recommendation noted that DMH has historically supported legislation regarding conditional release mechanisms for some forensic populations. These members would support a more proactive stance by DMH in this area of legislation and policy development.

e. **Information Sharing Across Providers of Care.** Within the limits of confidentiality, it is crucial that there be mutual confidence in the transparency of information at the time of discharge planning or referral to community-based services. DMH policy and practice must preclude withholding from providers information that bears upon the safety or risk management of the DMH consumer being referred or other DMH consumers served by the provider.

If a provider accepts a DMH consumer for services and subsequently discovers that the acceptance relied upon an incomplete case record or upon information that was misrepresented or withheld, it is not the responsibility of the provider to continue to serve the consumer if that consumer cannot be safely or adequately served by that provider. If information was withheld because the consumer declined to authorize release to the provider of that information, and if that information was critical for effective safety and risk management of the consumer or others, the appropriateness of the referral shall be jointly reviewed by the Area Medical Director and the Area Director of Community Services with consultation as appropriate with the Area Forensic Director Medical Director.

DMH consumers who will not authorize the exchange of relevant information critical to their risk management and recovery occasionally pose challenges under current law, regulation and DMH practice governing privacy. As specific subgroups of individuals who pose risk management challenges are identified, DMH may wish to review whether different privacy policies and protections might be warranted, particularly where the risks posed by the subgroup are to third parties (e.g., violence towards others, sexual aggression, fire setting) who may not be in a position to adequately protect themselves from victimization. As a consumer identified as being a high risk member of a specific subgroup progresses in effectively participating in lowering risk and progressing in recovery, more standard privacy protections might then be advanced.

Some Task Force members rejected this recommendation since they disagreed with the premise that a person's rights to privacy and other rights were dependent upon the degree of progress in recovery. They strongly felt that making the ability to protect privacy or make decisions about releasing information or participating in services should not be contingent upon the ability or willingness of the individual to effectively participate in

risk management or services; to the extent to which there may be exceptions to this general principle, these members felt that current procedures and practices were adequate to make the necessary adjustments in individual cases.

Other Task Force members strongly supported the recommendation, with the majority of the members offering no specific comment on this recommendation. Those supporting the recommendation and offering comment held that the existing practices and procedures set too high a standard for approving releases of information that were not authorized by the consumer when the information was important to risk management and service provision. They agreed that flexibility should exist to adjust expectations about privacy and program participation based upon a combination of factors such as: nature of the risk(s); to whom risk(s) is posed; severity, predictability and/or imminence of risk; ability/willingness to participate in risk management on the part of the consumer, DMH and service providers; and, role of program participation in addressing and managing risk.

f. **Clinical and Administrative Review of Community Capacity to Manage Clients with Intensive Needs and High Risk Behaviors.** Not all providers have the capacity to address particular kinds of client needs or potential risks that may arise from psychiatric acuity, neurocognitive difficulty, co-morbidity with substance abuse, medical compromise, histories of harming themselves and/or others, or other clinical factors. DMH should revisit existing "no reject" contract language and instead encourage providers to frankly express concerns they may have about their ability to safely and adequately serve a referred consumer. Clear mechanisms should be established in each Area that permit a clinical and administrative review of the appropriateness of a referral when a provider expresses safety, risk management, clinical or other concerns. An appeals mechanism that permits a Central Office review of unresolved disagreements should be implemented where either the provider or DMH are unsatisfied with the process at the Area level.

Some Task Force members could not support this recommendation. They argued that the "no reject" language in the contracts is intended to protect against providers picking the consumers they want and rejecting others.

Other Task Force members supported the recommendation, noting the good intentions of the "no reject" language but holding that in practice the "no reject" language is used at times to prompt providers to accept consumers that they reasonably believe they cannot adequately or safely serve.

Task Force members disagreed about whether or not DMH used "no reject" language to inappropriately prompt a placement, or if it occurs, the extent to which it occurs. One member observed that as DMH reprocures its services over time, different funding streams and provider capacities might be encouraged that would allow more options for placing individuals with elevated risk domains.

g. **Development of Treatment Expertise Across Settings, including Risk Assessment and Management Expertise, for Persons with Complex Needs.** The Department should adopt policies and practices that encourage providers to develop expertise in the treatment and management of specific populations. This might be done through a system of differential reimbursement and/or preferential referral for: (a) persons with complex mental illness treatment needs, including behavioral issues; (b) persons whose neurocognitive impairments make them more difficult to serve in settings created for persons without these impairments; or (c) persons with specific risk profiles that require heightened skill and experience for safety and risk management (e.g., sexually or physically aggressive, fire setting, suicidal, medically compromised). This might include specialized housing or clinical programming, specialized PACT teams, or other services intended to serve persons with one or more ongoing risk domains and intended to allow them to be safe in the community.

h. **Consideration of Statewide Programming in Specific Clinical Domains or with Specific Populations.** The Department should consider statewide programming for specific clinical and community services to serve persons with elevations in one or more risk domains. For example, statewide access to a community provider willing to operate congregate housing or serve sexually aggressive/problematic consumers may provide economies of scale and development of provider expertise. Statewide access to a provider willing to provide DBT services in group homes for persons with histories of chronic self-harm or to serve consumers with complicated medical needs may have similar advantages.

One Task Force member voiced disagreement with this recommendation based on previous experience with DMH efforts to create statewide programs for identified subpopulations of DMH consumers. These efforts were characterized as "failed" because Areas continued to have responsibility for serving the individuals (who typically wanted to live in their home Areas) but had insufficient authority to do so in statewide programs. This member reported that in cases when funding went to the Area for specialized program development, the existing performance-based contracting and monitoring systems resulted in effective programs in which other Areas could then purchase slots.

i. **Inventory and Utilization of Specialized Staff Skills Across DMH.** The Department has extraordinary expertise but there is currently no mechanism to consistently identify DMH staff with particular kinds of clinical, linguistic, cultural, or other expertise. DMH should inventory its staff for specific kinds of expertise that could be made available on a consultation basis in cases where safety and risk management issues require specialized consultation. This inventory should be maintained at Central Office and updated annually. DMH staff with expertise needed in specific cases should be made available for consultation along the entire continuum of care and services, including availability for support and case consultation to community based-providers.

j. **Area Based Risk Review Discussions and Collaboration.** As discussed elsewhere, each Area should establish a routine forum where Area providers and DMH Area staff and leadership with appropriate releases or other authorization have a meaningful opportunity to discuss ongoing challenges and opportunities, exchange information, and review successfully and less successfully managed risk incidents. .

Areas should also establish a routine forum where Area consumers and DMH Area staff and leadership have a meaningful opportunity to discuss ongoing challenges and opportunities, the experiences of consumers with DMH and DMH-contracted providers, and identify opportunities for increasingly more effective risk management strategies based in consumer engagement and support of recovery.

One Task Force member suggested removing the reference in the recommendation above to engagement and support of recovery. Others disagreed. One comment reflected the view that with optimal engagement in recovery there is optimal consumer participation in risk management and ideally diminished risk over time.

k. **DMH Safety and Risk Management Training Initiatives.** Both DMH and the provider community have significant training needs regarding safety and risk management concepts and practices. DMH should collaborate with the provider community to jointly train staff whenever possible and relevant to do so, and to offer training resources to providers to enhance the safety and risk management levels of provider staff and clinical professionals.

Most Task Force members commenting upon this recommendation strongly endorsed training as an essential component to an effective DMH risk management program.

l. **Advocacy for Protected Peer Review Opportunities.** DMH should support changes in statute and regulation that would afford DMH the "peer review" protections for clinically investigating adverse incidents that occur on inpatient units. If possible, this protection should be extended to include adverse incidents involving DMH consumers served in community settings.

Strategic Challenge Two: Currently existing safety and risk management protocols, practices and procedures vary widely across DMH Areas. While all Areas have mechanisms for identifying and assessing risk, these mechanisms vary in how proactive or reactive they are, how much they involve community providers, and who participates in decision-making under what circumstances. Different vocabularies are sometimes used to identify similar functions or roles.

Recommendations:

a. **All DMH Areas should explicitly adopt the Risk Identification Tool (RIT) developed by the Risk Assessment/Tools subcommittee of this Task Force and included as an Appendix to this Report.** As recommended by this subcommittee, the RIT should be completed upon initial contact with the DMH through any point of entry to DMH services and updated whenever there is a material change in circumstances (e.g., Critical Incident report, arrest, hospitalization), at least annually for inpatient clients, and for others whenever the ISP is updated. Alternatively, the RIT could be used in conjunction with the Kennedy version of the DSM-IV Axis V tool or other complementary tools that identify risk domains and can reflect changes within risk domains over time.

Whatever tool or protocol is ultimately adopted, it should be universally deployed across DMH and required of providers of contracted services. A routinely updated version should be maintained by both a designated point of case accountability within DMH and a point of clinical accountability (e.g., leader of an inpatient treatment team, person within a community service provider organization).

One Task Force member argued that adoption of the RIT or the Kennedy version of the DSM-IV Axis V tool was premature for a variety of reasons, but agreed that whatever tool or protocol was adopted should be implemented across all of DMH and providers of contracted services.

b. **All DMH Areas should explicitly adopt a shared, core risk management model informed by recovery, relapse prevention and "stages of change" concepts.** Risk assessment and management should be integrated as an essential component of adequate clinical care by DMH and contracted providers. DMH should adopt across all Areas the same language and vocabulary whenever possible to describe the same activities, functions and roles in safety and risk management activities.

c. **Areas should adopt a shared core set of standardized protocols for identifying, assessing, treating and managing risks of different kinds.** It is recommended that these protocols reflect the structure of the protocol devised by the Risk Assessment/Tools subcommittee (see Appendix) for assessing persons who pose a risk of violence to others. This protocol anticipates a universal and periodic screening for risk domains with the Risk Identification Tool (RIT). Different steps and tools are triggered depending upon which risk domains screen positive and require further assessment, but the basic structure

of screening and further assessment can be used with any risk domains.

If adopted by DMH, these protocols should use the same vocabulary across Areas to describe similar functions, activities or roles. Areas should reach a mutual consensus about what information would trigger specific steps beyond screening and initial level of assessment, what steps are taken by persons in specific roles, and under what circumstances review by senior Area staff (Area Director, Area Medical Director) or Central Office staff is required. Adoption of a core risk assessment and management protocol across Areas need not force either the adoption or elimination of other activities on the part of individual Areas. However, these other activities should serve a function in support of the system-wide core protocols and practices.

d. **Each Area should implement a structure that includes the following components**:

(1) An Area Risk Management Team to include, but not limited to, the Area Director, Area Medical Director, Area Forensic Director, Area Director of Community Programs/Services, Area Human Rights Officer, Site Directors, Directors of Child/Adolescent Services, and the COO and/or Medical Director of each hospital or major site;

(2) A Critical Incident Team to formally review any critical incidents or other adverse incidents warranting close attention;

(3) An Area DMH-Provider Meeting that meets routinely to discuss mutual concerns regarding referrals, resource, support. And consultation needs, and strategies to discharge from hospital or maintain in the community individuals who pose significant risk domain challenges; and,

(4) An Area DMH-Consumer Meeting that meets routinely to discuss mutual concerns regarding safety and risk management, consumer interactions with DMH and with DMH contracted providers, and consumer interactions with the broader community.

e. **DMH should establish in each Area at least one DMH clinician who would serve as an Area Risk Specialist and provide training, risk assessment and risk management consultation to DMH and to Area providers at all levels of care**. A primary goal of their function is to collaborate with providers assure effective interventions to consumers with complicated treatment and support needs who are served in the community. A primary goal would be to prevent involvement in the criminal justice system and/or inpatient hospitalization through provision of effective treatment, rehabilitation and support services.

Each Risk Specialist would be trained in assessment and consultation for the core risk domains (physical violence, sexual aggression, potentially lethal self-harm, medical compromise, risk of victimization). Risk Specialists who are not physicians will have identified access to appropriate medical consultation or support where cases involve medical compromise, or if the case is complex, will assist a physician assigned to the

case. In addition to competence in assessment and risk management in the core risk domains, each Risk Specialist will develop heightened expertise in one or more of the core risk domains and/or in another domain with lower frequency but requiring specialized skills (e.g., firesetting), as well as in Functional Behavioral Analysis and other skills helpful in retaining behaviorally challenging individuals in the community. Each Risk Specialist would serve and support the training, assessment, and risk management needs of the Area but would also be available to assist other Areas when specific additional expertise was required.

These Risk Specialists might be staffed at the Area level; alternatively, they might organizationally be staffed out of DMH Central Office as are Area Forensic Directors (AFD) currently. In either case, they would have a reporting relationship with the Area Director and the Area Medical Director just as the AFDs currently do. These Risk Specialists would be subjected to a program of specialized training and supervised case activity resulting in certification as a condition of ongoing employment, similar to the process of forensic certification for Designated Forensic Professionals (DFPs).

f. **Providers who were serving a consumer in the community at the time of hospitalization should be contacted at the very earliest opportunity to gather information regarding the specific circumstances giving rise to the hospitalization and any other relevant history or information**.

g. **Discharge planning should include detailed communication with anticipated providers regarding the clinical, safety, risk management and other needs of the consumer.** Involvement of an anticipated provider in discharge planning should begin at the earliest opportunity following identification of an anticipated provider.

h. **Consumers from an inpatient or community treatment setting who are deemed at ongoing risk within one or more of the risk domains should be discharged only after completion of the following: (1) a discharge plan identifying in detail individual needs and specifying how those needs will be met; and, (2) a safety plan identifying the most relevant risk and protective factors, the specific interventions that are in place to diminish risk factors and enhance protective factors, a discussion of the willingness and ability of the individual to consistently engage as a partner in managing risk, and any monitoring or containment needs required to maintain safety.** In some cases, the discharge and safety plan should be augmented with a specific crisis plan that identifies the individual's higher risk situations for any relevant risk domain, any observable indications that the person may be entering a period of elevated risk, and a detailed communication and response plan for each relevant risk domain in the event of emerging difficulty or onset of crisis. For example, a crisis plan would be important in risk management of persons at risk of rapid decompensation, frequent acute psychiatric hospital admissions, or present with fragile medical conditions.

i. **Each state hospital and major DMH site should have or have ready access to staff specifically trained in the use of specialized risk assessment instruments and tools**. For example, since risk of violence to others is a relatively common concern, these staff should be trained to use the HCR-20 and the Hare Psychopathy Checklist tools. A centralized process of training and standardization of protocols and use of risk assessment tools is essential to quality assurance of these procedures. A centralized process is also warranted for risk management review of cases that present heightened risk and management challenges due to psychopathy. A clinician with experience and training with these assessments and treatment challenges should be based centrally and available to all Areas to help ensure consistency of approach to screening, assessment and intervention.

j. **The current practice of providing Mandatory Forensic Reviews for a subgroup of inpatient clients deemed at elevated risk of physical and/or sexual violence should be revised.** The current practice of providing point-in-time forensic reviews of the privilege and discharge plans of inpatient treatment teams should be modified. Rather than providing point-in-time forensic reviews, a forensic consultant should be assigned to consult to the treatment team at the time the person is admitted; the consultant should work with the treatment team on safety and risk management planning, privileges, and discharge planning over the course of the hospitalization. Unlike the current model, the forensic consultant should then be made available to DMH staff (e.g., case management) or community clinical care and service providers to assist in the implementation of containment or risk management plans until the discharged person has stabilized in the community. The forensic consultant would then be available should the person later begin to encounter difficulty.

Depending upon case load and other duties, the modified MFR process might be implemented by the Area Risk Specialist. If the demands are too great for a single person, other clinicians can provide the modified MFR services. In any event, clinicians providing this kind of forensic consultation should be subject to specialized training and supervised practice akin to the current DFP and CJCC programs for court clinicians, but with content and skill sets specifically relevant to risk assessment/management of physical and/or sexual violence and behavioral stabilization on inpatient units and in community settings.

k. **The function of fact-finding when there have been complaints or adverse incidents should be more routinely and reliably integrated into quality assurance and improvement activities.** Currently, investigations into adverse incidents primarily serve a fact-finding function and are not integrated into processes of quality assurance and improvement that reliably allow for learning from specific incidents.

l. **The Commissioner should appoint an ongoing Safety and Risk Management Advisory Group to offer guidance and recommendations regarding the development and implementation of risk identification policies and practices throughout DMH**. This Advisory Group could recommend specific areas for review of policy and practice. For example, this Group might identify an area of controversy or need for further review such as differences in practice across inpatient units in how persons on a 15(b) remand status for treatment are granted privileges, or review of whether DMH should have separate regulations governing visitation and communication for persons on short-term forensic evaluation status, transfer for treatment from an incarceration setting, and persons on civil treatment status. Consumers should be represented and the Commissioner should consider appointing a consumer to a leadership position for the Advisory Group. DMH staff responsible for human rights and privacy protections should be part of this Advisory Group. The Group should also have public members and/or consultants with relevant experience.

Strategic Challenge Three: Many community-based providers hold that the needs of DMH consumers have increased in recent years, just at a time when providers increasingly struggle with staff recruitment, training and retention issues. Fiscal realities have forced programs to provide services with fewer line staff and less intense clinical supervision. As a result, community-based providers have expressed increasing anxiety about their ability to safely serve some DMH consumers with complex psychiatric and behavioral needs, and have articulated a sense that at times it seems that DMH is expecting providers to manage clients without a shared sense of responsibility for these clients.

Recommendations: In addition to other recommendations that more intensively involve providers in hospital care and discharge planning, provide consultation to safely support DMH consumers in the community, encourage specialization among providers to meet the needs of higher risk subgroups, and encourage frank discussion of safety and risk management issues, the following recommendations are offered:

a. **Providers who offer contracted services for persons at elevated risk in one or more risk domains should receive a special compensation rate.** This rate should be based upon factors including: (1) how many risk domains are elevated; (2) what intensity of services will be required to minimize likelihood of intolerable adverse incidents; (3) what intensity and kind of clinical services will be required to lower the risk domain(s) over time; (4) what kind of staffing stability, skill and training will be required to effectively implement any safety, crisis and clinical care plans; and, (5) the time and resources that will be required to effectively act as the point of primary clinical accountability for the consumer.

b. **Providers offering services for DMH consumers should have adequate internal risk assessment and management procedures.** Providers who provide services for persons determined to be at elevated and/or ongoing risk in one or more risk domains

should be required by the terms of their DMH contracts to: (1) have an internal risk assessment and management process consistent with DMH practices, and (2) to participate routinely in DMH risk management structures such as the Area DMH-Provider Meeting or actively collaborating with hospital treatment teams in discharge planning.

Additionally, providers serving DMH clients should be obligated to: (1) complete or update the Risk Identification Tool during their periodic case reviews or at any time the Tool needs to be updated on the basis of new information or events; (2) permit review of their internal risk assessment and management procedures generally or in specific cases involving DMH clients; and (3) describe in writing the scope of their capacity to adequately serve DMH clients with specific kinds of risk domains or clinical/functional challenges (e.g., neurocognitive impairment).

DMH and providers should work together to strengthen the capacity to avoid referring for services DMH clients whose risk domains, behavioral challenges, or functional capacities do not match the service array, risk management or clinical capacities of a particular provider.

c. **Risk management plans (e.g., safety and crisis plans as part of discharge planning) developed on inpatient units must be informed by appropriately authorized input from community-based providers who have worked previously with the client and/or are anticipated to be providing services following discharge**.

Risk management plans should be a standard part of hospital admissions and completed with the consumer upon or as soon as possible upon admission. The plan developed upon admission and modified as needed during the course of hospitalization should identify potential barriers to discharge. The plan developed during hospitalization by the time of discharge should include identification of warning signs for possible readmission. Training should be provided to hospital treatment teams regarding barriers or challenges to successful community living. Hospital treatment teams should increase collaboration whenever possible with providers on the goals of hospitalization and potential barriers to discharge or successful community living.

d. **Providers on the Task Force stressed the importance of having an accurate sense of the ability of an individual to productively and consistently participate in risk management plans. Similarly, inpatient clients should be intensively involved in discussions of their treatment plans (especially safety and crisis plans). Treatment while in the hospital should include specific opportunities to assess the concrete ability of individuals to support their own safety and risk management once discharged.**

e. **Risk management plans become part of the DMH case management record (if case managed), inpatient hospitalization records, and provider records.** Subject to appropriate releases or other authorization, risk management plans are transferred across levels of care or provider, are reviewed and updated as necessary as levels of care, sites

or providers change, and always follow the individual. Current risk management plans are shared with clinical care providers, providers of other DMH funded or supported services, local emergency services teams if they are an essential element in crisis planning, and others who need to be familiar with plans to carry out their roles in risk management or response.

f. **DMH should standardize treatment documentation and records, as well as procedures for accessing or exchanging information.** Providers represented on the Task Force report that it is very difficult at times to reliably gather or integrate information held by DMH because each DMH hospital or facility maintains its own documentation, medical or other records, and its own procedures for communication, accessing written and other information, appealing DMH decisions about the release of information.

g. **When persons are identified at elevated risk within one or more domains, there should routinely be assigned a point of accountability within DMH who will be responsible for maintaining contact with the person and/or providers, updating the risk assessment tools, and communicating with any point of clinical accountability.** Providers indicate that there are some persons who are at elevated risk in one or more risk domains but who received low intensity services and are not case managed by DMH.

DMH should ensure through its Area-based risk management procedures that consumers who have elevated risks in one or more domains are reviewed at regular intervals in one or more of the appropriate Area-based risk management meetings.

As part of the process of clarifying the role of DMH in providing services and an internal point of accountability for higher risk consumers, DMH should review its current processes for deciding to close cases when consumers reject DMH services. DMH should also articulate policy and expectations regarding practice when a higher risk consumer declines to accept services intended to address or manage risk but will accept other services. For example, what is the expectation of DMH when a person with a known history of sexual offenses will accept DMH housing but declines participation in a specialized intervention for mentally ill persons with histories of aggressive/problematic sexual behavior? What are the expectations when a person with a known history of serious assaults declines PACT because he finds it intrusive when he is abusing alcohol and other drugs?

h. **Alternatives to inpatient hospitalization should be created across the continuum of care to assist in risk management.** Providers indicated that the lack of readily accessible alternatives to inpatient hospitalization complicates the ability to adequately and safely serve higher risk consumers. Some cited situations in which a higher-risk individual had to deteriorate to the point of justifying acute inpatient admission because there were no accessible alternatives such as respite care or a crisis stabilization bed. The re-procurement of the DMH system of care affords an opportunity to purchase alternatives to inpatient beds. A statewide rather than Area-based purchase of some of these alternatives may allow for some specialization of programming (e.g., respite capacity for chronically self-harming persons will call for different staff skills than capacity for sexually aggressive persons).

Attachments: Risk Tools Subcommittee Final Report With:
Attachment A (Flow Chart)
Attachment B (Risk Identification Tool)

Attachments

Risk Assessment/Tools Subcommittee
For the DMH Risk and Safety Task Force

Subcommittee Report and Recommendations

Subcommittee Members:

Debra Pinals, M.D. (Chair)
Prudence Baxter, M.D.
David Hoffman, M.D.
Jacob Holzer, M.D.
Naomi Leavitt, Ph.D.
Ira Packer, Ph.D.
Gina Vincent, Ph.D.

Structure of Subcommittee:

In order to develop recommendations, the Subcommittee met on 1/12/06, 1/26/06, 2/9/06, 2/16/06, 3/6/06, 3/23/06 and 4/3/06.

The Subcommitttee was advised by Assistant Commissioner for Forensic Mental Health, Robert Kinscherff, Ph.D., J.D., and DMH State Medical Director, Mary Ellen Foti, M.D.

Subcommittee Charge:

The Subcommittee charge was to develop recommendations to assist DMH with risk management, incorporating the use of structured tools that may be available for the DMH population, as guided by evidence-based practices.

The Subcommittee was originally asked to examine multiple risk-related areas. Following discussion with the Subcommittee advisors, the Subcommittee decided to focus efforts by delineating suggestions for screening for multiple areas of risk in broad terms, and then expanding on identification and assessment specifically related to risk to public safety.

Subcommittee Recommendations:

I. Risk Screening and Identification Phase

Preamble: Clients who present with risk factors upon screening do not necessarily require the same degree of further assessment. The following recommendations are therefore written with the idea that the need for progressive levels of risk assessment depends on the results of previous screens or assessments. The Subcommittee developed a risk management flow diagram to illustrate the risk screening, identification, and assessment process across the DMH continuum of care (see Attachment A). The screening process pertains to screening of all major areas of risk.

A. Areas of potential risk for DMH clients have generally included the following five main areas of focus:
    1. Risk of violence (including risk of fire setting, risk of stalking)
    2. Risk of sexually problematic behavior
    3. Risk of suicide and self-harm
    4. Risk of incurring medical problems
    5. Risk of victimization

Recommendation 1: The risk management plan must include a mechanism to screen across all risk domains for DMH clients.

B. Once identified through a screening process, each domain of potential risk may warrant further review.

C. DMH currently has no one document or tool that provides a mechanism for rapid, reliable risk screening across domains. The CERF offered several advantages when it was initially adopted by DMH. However, this assessment has not been updated to reflect advances in the field. For example, based on current evidence, numerical risk assessment scores can be misleading if not based on clear factual anchors. In addition, some risk assessments in various domains of functioning require more specific training, and the inter-rater reliability for these tools must be continually assessed. In response to these issues, the Subcommittee utilized the foundations of the CERF and current developments in risk assessment to inform the development of a Risk Identification Tool (RIT) for screening risk.

Recommendation 2: A screening tool used to assess risk for all DMH clients must provide a simplified factual account focused on known risk variables. Therefore, use of the attached Risk Identification Tool (RIT; Attachment B) is recommended for screening risk factors for all clients who enter the DMH system.

Recommendation 3: The Subcommittee endorses that the RIT replace the CERF, and that the RIT should become the risk screening document that will travel with DMH clients across systems of care throughout their tenure within DMH, with periodic updates.

D. DMH clients are provided services through complex intersecting systems of care. Over time risk factors may change. Therefore, risk screening must be updated on a regular basis and as circumstances warrant.

Recommendation 4: The RIT should be completed at the time of DMH eligibility determination and updated periodically including 1) at the time of any client-related Critical Incident Report, 2) at the time of entry to a DMH facility, 3) at the time of transition from a correctional environment into the community, and 4) at least annually for inpatients and whenever the ISP is updated.

E. Discussions were held regarding early risk identification among children/adolescents. It is important to recognize that this population presents with unique variables that are important to consider in any risk assessment and risk management process.

Recommendation 5: The Subcommittee agreed that a RIT for children (RIT-C) should be developed to screen for risk factors among youth in the DMH system.

II. Risk to Public Safety: Risk Assessment Phase

Preamble: The following Subcommittee recommendations focus only on the assessment for risk of harm to others. The Subcommittee determined that developing a protocol for risk assessment related to public safety concerns could provide a template that could become a basis for the development of models pertaining to the assessment and management of other areas of risk (see Recommendation 24).

A. Once a screening tool has been completed, as in all areas of health care, a system of multi-tiered further assessment is generally conducted, to allow for increasingly more sensitive and more specific assessment of the clinical issue(s).

Recommendation 6: After completion of the RIT screening tool, the need for a second level of review of a client's risk of harm to others should be determined.

Recommendation 7: As delineated after Stage 1 of the flow diagram, a triage determination of a need for further violence risk assessment should be made. This should be guided by a policy that sets forth threshold criteria for further review (e.g., those that have a history of an MFR or an MFR charge, those that are SORB involved, and those that would warrant additional review based on predetermined additional risk variables and a clinical decision).

Recommendation 8: The Subcommittee recommends that the determination of a need for further violence risk assessment should be made at the Area level, guided by a policy as described in Recommendation 7.

B. Current violence risk assessment literature supports the use of clinical history gathering combined with the use of guided assessment tools. These tools utilize empirically-based violence risk factors and incorporate them into risk management planning. There are several types of instruments, ranging from

pure actuarial, to those that are considered more clinically-driven and inclusive of dynamic risk factors (i.e., those that are amenable to change and not simply historic). General guided violence risk assessment tools widely available could be used in conjunction with a mechanism for a clinical historical review. The existing Violence Behavior Assessment Form (VBAF) has provided a good basis to help DMH inpatient treatment teams gather risk-related history. However, the Subcommittee believes that the VBAF as it currently exists within MHIS is problematic.

Recommendation 9: A revised version of the VBAF (VBAF-R) should be developed.

Recommendation10: Treatment providers should complete a VBAF-R on all patients who have been identified as needing a higher level of violence risk assessment. This recommendation requires the development of the capacity of community treatment providers to complete a VBAF-R.

Recommendation 11: Once the VBAF-R is completed on a given client, a clinician who is qualified to do so should complete a Psychopathy Checklist-Screening Version (PCL:SV; a measure used to generate a score that provides information as to where the client fits along dimensions of psychopathy, which has been strongly correlated with risk of violence) as well as an HCR-20 (a tool that utilizes historical, clinical and risk management variables to help assess an individual's violence risk), and develop clinical risk management recommendations.

> *Explanatory Note: We would anticipate that the work-product at this stage (Stage 2 in the flow diagram) would consist of a relatively brief report. The report would be attached to the VBAF-R and would include the PCL:SV score and an explanation thereof, a description of the items within the HCR-20 that reflected mitigating and aggravating risk factors, as well as brief clinical recommendations based on the overall assessment.*

Recommendation 12: After the completion of the assessments outlined in Recommendation11, each case should be reviewed for the need for further risk assessment and risk management intervention.

Recommendation 13: A triage determination of the need for further risk assessment and risk management intervention should be conducted through a policy that sets forth threshold criteria for further review. For this stage of the risk assessment process we recommend that:

a. a state-wide centralized process of review be developed for maximal consistency and oversight regarding the need for further review, and

b. clinical risk assessment triage decisions and review at this level should be conducted by clinicians with experience utilizing the PCL:SV and HCR-20.

C. By way of background regarding the need for additional layers of risk assessment and risk management, the Subcommittee reviewed the current Mandatory Forensic Review (MFR) policy and process. The MFR program was initially developed with two goals in mind. The first was to provide treatment teams with quality risk assessments on patients who fall into higher risk categories by virtue of some aspects of their history. Over the years, teams have grown better and better at identifying these patients (as defined by the policy), and now it is rare that an "MFR patient" is given privileges or discharged without forensic division review. As such, this goal has been met.

The second goal of the MFR program was to increase treatment teams' understanding of risk assessment theory and practice such that they would develop the internal capacity to conduct sophisticated risk reviews on their own. However, based on experiences of the Subcommittee members in reading and conducting MFRs, reading MFR referrals, and working with MFR evaluators and treatment teams, the Subcommittee agreed that this second goal has not consistently been met. The Subcommittee is of the opinion that simply providing the opportunity to read completed risk assessments is not a sufficient mechanism to teach the underlying principles or guide risk management of challenging patients.

Recommendation 14: The Subcommittee recommends the adoption of the proposal first developed by Naomi Leavitt, Ph.D., related to utilizing expertise of forensic clinicians in assisting treatment teams with risk management. This would also further the goal of educating treatment teams in violence risk assessment and management. The proposal consists of the following:

a. Teams will be provided with a didactic presentation on risk assessment;

b. At the point it is decided that a patient will require a further level of forensic assessment (corresponding to 3 in the flow diagram), a forensic consultant will be assigned, and a treatment team member will be designated to coordinate with the consultant, on that particular case.

c. The forensic consultant and treatment team member will then have ongoing telephone consultations about what data to gather, why certain pieces of information are critical to risk assessment, how the team could be working on treatment in light of the identified risk factors, etc.

d. When/if a referral for further forensic review needs to be written, the treatment team member would theoretically be much more informed about what data to include, and the forensic consultant will consult on the write-up. The forensic consultant may also work with the treatment team member in updating the VBAF-R data in light of any new findings or case considerations.

e. The consultant interviews the patient, with as many treatment team members as possible present.

f. After the interview, the consultant and the team meet, and opinions and recommendations are generated and discussed during at this meeting. This active consultation model could serve to replace the role of the long forensic report (i.e., what might be a typical current MFR Report). To document the risk assessment and risk management work done with the team, a briefer report is generated by the forensic consultant. This report would serve primarily to reiterate what had been (thoroughly) discussed at the meeting, unless a more thorough report was thought to be needed in a given case.

Recommendation 15: The Subcommittee recommends that this risk assessment/risk management model be piloted at one facility. Tewksbury Hospital is suggested because of changes in that facility that dovetail with creation of a new MFR model, and because Dr. Leavitt has already had initial discussions with Tewksbury Hospital administration, which is very receptive to the idea.

If successful, the Subcommittee recommends incorporation of such a model into the Department's overall risk assessment program.

Recommendation 16: In addition to utilization of active risk management case consultation in hospital settings, the Subcommittee recommends that this model of a second tier consultation for additional risk assessment and risk management should be adapted for community clients.

Recommendation 17: Every DMH Area must develop a system to incorporate violence risk assessment information into treatment planning at each stage of the risk screening, identification and assessment process. Such a system should include a mechanism to monitor whether this is being done appropriately.

D. Several DMH staff participated in an initial training for the use of the PCL:SV. Of those, only a few have actually practiced using the PCL:SV with sample cases (which is a requirement for the use of the instrument). It is likely that even fewer have implemented the HCR-20. Staff who would not be administering these tools should be educated about the purpose of these tools, including their strengths and limitations.

Recommendation 18. Identify appropriate staff to complete the HCR-20 and PCL:SVs on patients.

Recommendation 19: Develop mechanisms to train appropriate staff to complete the HCR-20 and PCL:SV. Training should also be designed for those who will be using the results but not coding the HCR-20 and PCL:SV instruments.

Recommendation 20: Develop a system of quality assurance to ensure standards of practice remain consistent and high.

E. Risk management for children/adolescents will need analogous procedures as those designed for adults, although the details will need to be tailored to suit the unique risk issues found among children/adolescents. Use of the PCL:SV is not appropriate for children/adolescents under age 19, and there is mixed data related to the use of psychopathy screening measures for youth.

Recommendation 21: The Subcommittee agreed that in addition to developing a RIT-C for children, a mechanism of further assessment of violence risk and risk management should be developed by a workgroup with collective expertise in violence risk assessment in this population.

F. Obtaining criminal history from both the subject and collateral sources is considered a mainstay of risk assessment practice when public safety concerns are at issue. Although there has been concern related to stigma in asking for criminal record histories (i.e., CORI checks), the Subcommittee believes that the stigma has lessened as these reviews are commonly requested for employment, training programs, etc. Without knowing a client's criminal history based on objective data, one may be at risk of liability for not assessing risk fully based on current clinical practice. To only check a CORI after an unfortunate, untoward event may mean that significant risk issues were missed when there may have been informed preventive strategies implemented beforehand.

Recommendation 22: Obtain CORIs on all persons deemed DMH eligible or at entry into the DMH system, in addition to the current practice of obtaining CORIs at the time of all inpatient admissions.

G. The Subcommittee discussions were extensive regarding management of other areas of risk. Based on those discussions additional recommendations are offered.

Recommendation 23: Regarding the assessment of risk of sex offending and risk of engaging in problematic sexual behavior, we recommend the utilization of the same principles outlined herein, incorporating a multi-tiered risk review process. We do not endorse the use of pure actuarial instruments in this process. Rather, we would support the use of risk management instruments validated on populations similar to that found in DMH, in combination with clinical approaches to risk management. One such promising tool is the Risk for Sexual Violence Protocol (RSVP), which is unique in that it was developed specifically for a population of persons with mental illness and it is based on structured clinical judgment and attention to dynamic variables. Relevant validation data is reportedly forthcoming.

Recommendation 24: For additional types of risk assessment (e.g., risk of suicide, medical risk, neurocognitive risks etc), DMH should consider the development of a tiered risk review and assessment process similar to that outlined herein beginning at Recommendation 6. DMH clinicians with specific expertise in those other areas should be brought together to develop these processes.

H. The area of risk assessment is complex and changing. Thus, the above recommendations represent only a beginning. Ongoing discussions of the DMH risk assessment process with review of effectiveness and feasibility should continue over time.

Recommendation 25: For the purpose of programmatic Performance Improvement and assessment of a cost-benefit analysis regarding utilization management with the implementation of the above recommendations, there will need to be a rigorous mechanism to measure the implementation and efficacy of the recommendations delineated in this report. We recommend that information related to the violence risk screening, identification and assessment process should be systematically collected in a formal manner. We further recommend that information gathered include a measure of desired outcomes for the program and a means of evaluating the program based on follow up of individual cases over time. Such programmatic assessments should be reviewed on a regular basis to allow for improvements as needed.

Attachments:

A: DMH Violence Risk Assessment Flow Diagram
B: Example of DMH Risk Identification Tool for screening (RIT)